

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at New Britain		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Brittany Farms Rd New Britain, CT 06053	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, clinical record review, facility documentation, and facility policy, the facility failed to maintain a safe environment for residents in two distinct areas, resulting in the findings of Immediate Jeopardy. First, the facility failed to conduct adequate monitoring of hot water temperatures and to communicate and act upon documented temperatures exceeding 120 F, resulting in water temperatures ranging from 126.3 F to 145.4 F in 44 of 64 resident rooms on the second and third floors. Second, for one (1) of three (3) sampled residents (Resident #11) reviewed for respiratory care, the facility failed to maintain a safe environment for a resident receiving continuous oxygen therapy when Nurse Aide staff applied a petroleum-based ointment to Resident #11's nares and face without a physician's order, without proper assessment, and without recognition of the flammability risk; staff failed to remove the flammable material from Resident #11's room and the facility failed to educate staff on the danger of using petroleum-based products with oxygen therapy. These failures exposed residents to a risk of scalding from excessive water temperatures and exposed Resident #11 to a significant fire risk and potential respiratory complications, resulting in the findings of Immediate Jeopardy. Additionally, for one (1) of eight (8) sampled residents (Resident #13) reviewed for accidents, the facility failed to consistently implement a prescribed floor mat fall prevention intervention for a resident with a history of falls and a care-planned floor mat. The findings include1. Observation on 4/20/2026 at 11:33 AM identified hot water temperatures exceeded 120 F in 44 out of 64 rooms observed on the second and third floors, water temperatures ranged from 126.3 F to 141.4 F. The Facilities Director (Maintenance Director) was immediately notified to test water temperatures with the surveyor. Observation, interview, and review of facility documentation with the Facilities Director on 4/20/2026 at 12:00 PM using a surveyor calibrated thermometer and a facility calibrated thermometer, hot water temperatures were noted to exceed 120 F in 16 out of 16 rooms tested. Water temperatures ranged from 120.8 F to 145.4 F. He identified that acceptable water temperatures were between 105 F and 120 F and water temperatures were checked daily in random rooms by the assigned Maintenance Technician. If temperatures had been outside the acceptable range, he should have been notified, and he would adjust the mixing valve and re-checked the temperature an hour later to ensure appropriate water temperatures. Review of the facilities daily water temperature logs identified documented water temperatures on 3/9/2026 were 120.4 F in room [ROOM NUMBER], on 3/16/2026 were 121.4 F in room [ROOM NUMBER], on 3/30/2026 were 120.4 F in room [ROOM NUMBER], on 4/6/2026 were 120.5 F in room [ROOM NUMBER], on 4/6/2026 were 122.6 F in room [ROOM NUMBER], on 4/8/2026 were 120.4 F in room [ROOM NUMBER], on 4/14/2026 were 120.3 F in room [ROOM NUMBER], on 4/15/2026 were 121.4 F in room [ROOM NUMBER], located on the 2nd and 3rd floor floors. The Facilities Director indicated that he was unaware of the high-water temperature readings, had never been notified, but should have been made aware by the Maintenance Technician who took the above normal water readings. Additionally, the Facilities Director noted the corrective action would have been to adjust the mixing valve and recheck temperatures to ensure safe water temperatures. The interview failed to identify the reason water temperatures had not been (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Interview and observation with NA #1 on 4/22/2026 at 10:40 AM identified that she had applied the house stock lotion, Derma Daily (a moisturizing lotion containing petroleum as an ingredient) mixed with the house stock of Tendor Phor (a skin protectant moisturizing ointment with 44.28% petroleum jelly) to Resident #11's cheeks, nose, and inside his/her nares because Resident #11 had dry skin and the combination of the 2 lotions together was more effective to relieve Resident #11's dry skin. NA #1 indicated that she was not aware she should not be applying a petroleum-based product to residents receiving oxygen and was never informed or educated of the safety risk. Located inside Resident #11's dresser was one 4-ounce bottle, 50 percent (%) full of Derma Daily moisturizing lotion with Aloe Vera and one 4-ounce tube, 25 % full of Tendor Phor skin protectant moisturizing ointment with petroleum. NA #1 indicated that she would clean Resident #11's face, discard the remaining lotions and ensure she did not use the products together in the future. Re-interview with LPN #1 on 4/22/2026 at 10:51 AM identified that she was not aware NA #1 had applied a petroleum-based product to Resident #11's face. LPN #1 indicated that if she had known she would have stopped NA #1 from applying the lotion, would have removed product, and would have educated NA #1 of the safety risk of using petroleum based products with oxygen, and notified her supervisor. Interview with the Director of Nursing (DON) on 4/22/2026 at 10:59 AM identified she was not aware facility staff were applying petroleum-based products to Resident #11 face while being administered oxygen and that they should not be doing so because of the severe safety risk. She conducted a complete audit, the prior week, of all resident physician's orders to ensure no resident was prescribed the use of a petroleum jelly product, and she did not identify any petroleum jelly products ordered. The DON indicated that while the facility did complete an audit, they did not educate facility staff or check the house stock to see if there were any petroleum-based products in stock. The DON indicated that she would immediately educate all staff and remove all petroleum-based products from the facility. Interview with the oxygen's company Chief Operating Officer (COO) on 4/24/2026 at 9:47 AM identified that petroleum-based products should not come in contact with oxygen and it posed a severe safety risk due to its flammability potential. Additionally, the COO indicated that the oxygen company did not provide any policies or education to the facility about not using petroleum-based products and oxygen together as it was common knowledge. Review of the Tendor Phor ointment ingredients and directions for use indicated it was a Petrolatum (petroleum jelly) based ointment. Review of the Tendor Phor ointment Safety Data Sheet (SDS) identified vapors from the product may form explosive mixtures with air. Review of the facilities Oxygen Safety policy dated 12/21/2022, directed in part that licensed staff using oxygen equipment will be trained in its operation, safety precautions and manufacturer's instructions for using the oxygen equipment. Training will occur upon hire and periodically for review of safety guidelines and usage requirements. According to the American Lung Association, aside from the immediate fire risk, the primary medical danger for this resident is aspiration pneumonia (specifically lipid pneumonia). Because petroleum jelly is a lipid-based ointment, small particles can be inhaled or wicked into the lungs through the nose or mouth. Over time, these oils accumulate in the lungs because the body cannot easily clear them, leading to: Inflammation of the lung tissue, Chronic coughing or chest pain, Irreversible lung scarring (fibrosis). For a resident who already requires continuous oxygen, their respiratory reserve is low, making this secondary lung irritation particularly dangerous. The failure of NA #1 to recognize the severe safety risk when applying petroleum-based jelly inside the nares of a resident who was being administered oxygen, the lack of education given to facility staff, and the failure to provide interventions to prevent and protect residents from the severe safety risk resulting in a finding of Immediate Jeopardy. On 4/22/26 at 3:30 PM the Immediate (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Jeopardy (IJ) Template was provided via email to the Administrator. On 4/22/26 at 3:53 PM the facility submitted the removal plan which was accepted by the State Agency. The removal plan included: Rooms of residents on oxygen had their rooms checked to ensure there were no petroleum-based products stored in their room. Nursing staff would be educated to ensure that residents on oxygen do not have petroleum-based products stored in their rooms. Random audits of residents on oxygen will be conducted by the nursing supervisor or designee each shift for the next 24 hours to ensure that residents on oxygen do not have petroleum-based products stored in their room. The Immediate Jeopardy was removed on 4/22/2026 at 3:55 PM. 3. Resident #13 diagnoses included unspecified dementia, epilepsy, and cataracts. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #13 had a Brief Interview of Mental Status of 6 indicating severe cognitive impairment, and was totally dependent on staff for transfers, changing positions in bed (rolling left to right and sitting to lying), and dressing. The Fall Risk Evaluation dated 3/13/2026 at 2:31 PM identified Resident #13 was at moderate risk for falls. The Resident Care Plan dated 3/16/2026 identified Resident #13 had an actual fall. Interventions included applying a floor mat next to bed (when in bed), reinforcing safety awareness and ensuring the call light was within reach. Resident #13's undated Nurse Aid Resident Care Card (directive for care) directed to apply a floor mat next to the bed (when Resident #13 was in bed) and remove the mat when Resident #13 was out of bed. The Interdisciplinary Team nurse progress note dated 4/9/2026 at 2:14 PM identified Resident #13 did not experience any falls in the past quarter, had a history of falls and the Resident Care Plan was reviewed and updated with individualized interventions to meet his/her needs. Observations on 4/21/2026 at 9:32 AM and at 10:30 AM, identified Resident #13 in bed without the benefit of a floor mat positioned next to the bed, and gray floor mat stored propped against the wall beneath the window. Observation and interview with Nurse Aide (NA) #2 on 4/23/2026 at 7:05 AM identified Resident #13 in bed, with a floor mat positioned on the floor parallel to the bed, an over the bed table was placed on top of the floor mat, also parallel to the bed. Interview with NA #2 identified that Resident #13 had a floor mat in place as a precaution in case the resident rolled out of bed, and that the over the bed table should not be positioned on the mat because the mat was intended to protect Resident #13 from injury if he/she fell. NA #2 was unable to identify who placed the over the bed table on the mat, and subsequent to surveyor inquiry removed the over the bed table from the mat. Interview with the Registered Nurse Unit Manager (RN) #1 on 4/23/2026 at 7:08 AM identified that the over the bed table should not have been placed on top of the floor mat, as doing so defeated the purpose of the mat in preventing Resident #13 from sustaining injuries should he/she roll out of bed. Additionally, RN #1 stated she was unsure of the facility policy on floor mats but further stated that the NAs and any staff who observed Resident #13 were responsible for ensuring that the floor mat was properly placed when the resident was in bed and that no items, such as an over the bed table, should be placed over the mat. Observation on 4/24/2026 at 8:40 AM identified Resident #13 in bed without the benefit of a floor mat positioned next to the bed, the gray floor mat was propped against the wall beneath the window. Review of the Falls and Fall Risk Management Policy reviewed 4/19 directed in part that staff will identify interventions related to the residents' specific risks and causes to try to prevent the residents from falling and to try to minimize complications from falling. Additionally, the staff with input from the attending physician will implement a resident centered fall prevention plan.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 of 8 residents (Resident #16) reviewed for accidents, the facility failed to report an injury of unknown origin (bruise above the left eyebrow) to the state agency within established timeframes. The findings include: Resident #16's diagnoses included dementia, cerebral infraction, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 had severely impaired cognition, and was totally dependent on staff for transfers, changing positions in bed (rolling left to right and sitting to lying), and personal hygiene. The Resident Care Plan dated 12/4/25 identified Resident #16 had potential impairment to skin integrity related to inactivity. Interventions included using caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces and to follow facility protocols for treatment of injury. Review of the January 2026 physician's orders directed to transfer the resident via a hoist lift (mechanical lift). A Change in Condition/Concurrent Review dated 1/22/26 at 7:30 AM identified a bruise on Resident #16's left eyebrow that measured 1.5 cm x 0.5 cm. A nurse's note, written by the DNS, dated 1/22/26 at 7:30 AM identified Resident #16 bumped his/her forehead lightly on the mechanical lift bar during a transfer. The DNS further documented that post event it was noted that the resident acquired a reddish/purplish discoloration above his/her left eyebrow. (This is in conflict with accident/incident statements and documentation that did not identify the resident bumped his/her head on the mechanical lift bar, did not determine when the bump occurred, an interview with the DNS who indicated she could not identify who reported the resident bumped his/her forehead on the mechanical lift bar and surveyor interviews that failed to reflect the resident had bumped his/her head). Review of an Accident/Incident Investigation Staff Interview, written by a nurse aid (who found the bruise), dated 1/22/26 at 7:30 AM identified she found the discoloration on Resident #16's left eye when she entered the room to provide morning care. This was reported immediately to the nurse. Review of the Accident/Incident Investigation statements failed to identify a statement indicating Resident #16 bumped his/her head on the mechanical lift bar. Review of facility documentation failed to reflect that the facility had completed a reportable event form/risk management system entry (RMS) regarding the reddish/purplish discoloration (bruise) above his/her left eyebrow with an unknown etiology. Review of the state agency online reportable events portal failed to reflect that bruise on Resident #16's left eyebrow that measured 1.5 cm x 0.5 cm, with an unknown etiology, had been reported. Interview with RN #1 on 4/22/26 at 9:17 AM, (Unit Manager of Resident #16's unit, and who is responsible for starting the RMS, the change in condition assessment to complete and follow up on any reportable event that occurs on that unit, including obtaining statements per interview with DNS) identified if a bruise is found, the nurses would be responsible to start the RMS, and initiate a change in condition form, and the RN obtains the statements and reviews and locks the change in condition assessment and RMS. Further, all of the documentation is kept by the ADNS. Additionally, a 72-hour lookback for staff on the unit is done to obtain interviews. Review of the clinical record with RN #1 identified an RMS was never completed after the bruise on Resident #16's left eyebrow, that measured 1.5 cm x 0.5 cm, was found. RN #1 indicated an RMS should have been completed at the time of the incident, and although she was the unit manager and responsible for compiling statements, which RN #1 indicated she did obtain, the ADNS would have the statements at this point. Interview with the Assistant Director of Nurses (ADNS) on 4/22/26 at 9:44 AM identified that, according to facility policy, Accident/Incident reports are to be completed by the RN Supervisor for all falls, suspected injuries, abrasions, skin tears, and skin discolorations. These reports are then reviewed by the ADNS and DNS and, if necessary, reported to the state agency. Review of Resident #16's clinical record failed to identify a completed RMS. Although RN #1 previously stated that the ADNS would (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have the information/statements related to Resident #16's bruise that was found on 1/22/26, the ADNS indicated she did not have any documentation or statements regarding that incident. Further, although all reportable incidents are tracked sequentially on a log kept by the ADNS, the ADNS identified the bruise found on Resident #16's forehead had not been logged, which the ADNS indicated means that an accident/incident report / RMS had not been done. Further, the ADNS indicated that RN #1 might have the missing documentation even though the even occurred 3 months ago. Re-interview with RN #1 on 4/22/26 at 2:40 PM identified that she found the interview statements related to Resident #16's bruise to the left eyebrow observed on 1/22/26, misfiled in an unmarked folder in her desk drawer. RN #1 stated that although she did not complete the RMS (though she should have) she did review the statements for the 72-hour lookback. Based on this review, she believes the discoloration may have occurred because Resident #16 requires a total mechanical lift transfer, becomes anxious, and often grabs the bar, which could cause him/her to bump against the machine. RN #1 also noted that the resident can pull up on the side rail during care, which could also lead to a bump and discoloration. RN #1 stated she did not consider the discoloration to be an injury of unknown origin because she assumed one of these scenarios had occurred. However, after reviewing the Accident/Incident information she indicated that there were no statements from staff in her possession indicating that the resident actually bumped him/herself on the side rail or lift. RN #1 further stated that she is responsible for reporting injuries of unknown origin to the Director of Nursing immediately upon reviewing the 72-hour lookback. Although she felt confident about what might have happened to Resident #16, she indicated that without documentation to support the assumption, she should have notified the DNS. Interview with the DNS on 4/23/26 at 8:53 AM identified that facility policy required all injuries of unknown origin to be investigated, which was part of the abuse policy, and if no apparent cause is identified, the incident must be reported to the state agency (this is in conflict with state and federal law as injuries of unknown origin are indicators of abuse and are to be reported within 2 hours of identification). The DNS could not identify how she determined that the bruise on Resident #16's forehead was caused by the resident bumping the mechanical lift bar or who reported that to her but stated she would not have signed off on the assessment if she had not been sure that occurred. Additionally, the DNS noted that she might have additional interview statements in her office. However, she stated that it is ultimately the responsibility of the unit manager to follow up on all Accident/Incident reports to ensure they are complete. Follow-up interview with the DNS on 4/24/26 at 9:46 AM identified that she was unable to locate any additional interviews or documentation regarding the discoloration to the residents left eyebrow which would indicate that Resident #16 had hit his/her head on the mechanical lift bar during a transfer. Review of the Abuse, Neglect and Exploitation Policy directed that possible indicators of abuse include but are not limited to physical marks such as bruises or patterned appearances and physical injury of a resident of unknown source. Additionally, reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specified timeframes: immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will follow up and report the results of the investigation when final within 5 working days of the incident as required by state agencies.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 of 8 residents (Resident #16) reviewed for accidents, the facility failed to thoroughly investigate an injury of unknown origin. The findings include: Resident #16's diagnoses included dementia, cerebral infraction, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 had severely impaired cognition, and was totally dependent on staff for transfers, changing positions in bed (rolling left to right and sitting to lying), and personal hygiene. The Resident Care Plan dated 12/4/25 identified Resident #16 had potential impairment to skin integrity related to inactivity. Interventions included using caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces and to follow facility protocols for treatment of injury. Review of the January 2026 physician's orders directed to transfer the resident via a hooyer lift (mechanical lift). A Change in Condition/Concurrent Review dated 1/22/26 at 7:30 AM identified a bruise on Resident #16's left eyebrow that measured 1.5 cm x 0.5 cm. A nurse's note, written by the DNS, dated 1/22/26 at 7:30 AM identified Resident #16 bumped his/her forehead lightly on the mechanical lift bar during a transfer. The DNS further documented that post event it was noted that the resident acquired a reddish/purplish discoloration above his/her left eyebrow. (This is in conflict with accident/incident statements and documentation that did not identify the resident bumped his/her head on the mechanical lift bar, did not determine when the bump occurred, a later interview with the DNS who indicated she could not identify who reported the resident bumped his/her forehead on the mechanical lift bar and surveyor interviews that failed to reflect the resident had bumped his/her head). Review of an Accident/Incident Investigation Staff Interview, written by a nurse aid (who found the bruise), dated 1/22/26 at 7:30 AM identified she found the discoloration on Resident #16's left eye when she entered the room to provide morning care. This was reported immediately to the nurse. Review of the Accident/Incident Investigation statements failed to identify a statement indicating Resident #16 bumped his/her head on the mechanical lift bar. Review of facility documentation failed to reflect that the facility had completed a reportable event form/risk management system entry (RMS) regarding the reddish/purplish discoloration (bruise) above his/her left eyebrow with an unknown etiology. Review of the state agency online reportable events portal failed to reflect that bruise on Resident #16's left eyebrow that measured 1.5 cm x 0.5 cm, with an unknown etiology, had been reported. Review of facility documentation identified the usual staffing during the 11:00 PM - 7:00 AM shift on Resident #16's unit included 2 nurse aides and 1 LPN. Review of the investigative statements regarding Resident #16's bruise, which was found at 7:30 AM on 1/22/26 identified statements were not obtained from the one LPN who worked on 1/19/26 during the 11:00 PM - 7:00 AM shift or from the four nurse aides that worked on 1/19, 1/20 or 1/21/26 during the 11:00 PM - 7:00 AM shifts, as part of the lookback according to facility policy. Interview with RN #1 on 4/22/26 at 9:17 AM, (Unit Manager of Resident #16's unit, and who is responsible for starting the RMS, the change in condition assessment to complete and follow up on any reportable event that occurs on that unit, including obtaining statements per interview with DNS) identified if a bruise is found, the nurses would be responsible to start the RMS, and initiate a change in condition form, and the RN obtains the statements and reviews and locks the change in condition assessment and RMS. Further, all of the documentation is kept by the ADNS. Additionally, a 72-hour lookback for staff on the unit is done to obtain interviews. Review of the clinical record with RN #1 identified an RMS was never completed after the bruise on Resident #16's left eyebrow, that measured 1.5 cm x 0.5 cm, was found. RN #1 indicated an RMS should have been completed at the time of the incident, and although she was the unit manager and responsible for compiling statements, which RN #1 indicated she did obtain, the ADNS would have the statements at this point. Interview with the Assistant Director of Nurses (ADNS) on 4/22/26 at 9:44 AM identified that, according to facility policy, Accident/Incident (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reports are to be completed by the RN Supervisor for all falls, suspected injuries, abrasions, skin tears, and skin discolorations. These reports are then reviewed by the ADNS and DNS and, if necessary, reported to the state agency. Review of Resident #16's clinical record failed to identify a completed RMS. Although RN #1 previously stated that the ADNS would have the information/statements related to Resident #16's bruise that was found on 1/22/26, the ADNS indicated she did not have any documentation or statements regarding that incident. Further, although all reportable incidents are tracked sequentially on a log kept by the ADNS, the ADNS identified the bruise found on Resident #16's forehead had not been logged, which the ADNS indicated means that an accident/incident report / RMS had not been done. Further, the ADNS indicated that RN #1 might have the missing documentation even though the even occurred 3 months ago. Re~interview with RN #1 on 4/22/26 at 2:40 PM identified that she found the interview statements related to Resident #16's bruise to the left eyebrow observed on 1/22/26, misfiled in an unmarked folder in her desk drawer. RN #1 stated that although she did not complete the RMS (though she should have) she did review the statements for the 72~hour lookback. Based on this review, she believes the discoloration may have occurred because Resident #16 requires a total mechanical~lift transfer, becomes anxious, and often grabs the bar, which could cause him/her to bump against the machine. RN #1 also noted that the resident can pull up on the side rail during care, which could also lead to a bump and discoloration. RN #1 stated she did not consider the discoloration to be an injury of unknown origin because she assumed one of these scenarios had occurred. However, after reviewing the Accident/Incident information she indicated that there were no statements from staff in her possession indicating that the resident actually bumped him/herself on the side rail or lift. RN #1 further stated that she is responsible for reporting injuries of unknown origin to the Director of Nursing immediately upon reviewing the 72~hour lookback. Although she felt confident about what might have happened to Resident #16, she indicated that without documentation to support the assumption, she should have notified the DNS. Interview with the DNS on 4/23/26 at 8:53 AM identified that facility policy required all injuries of unknown origin to be investigated, which was part of the abuse policy, and if no apparent cause is identified, the incident must be reported to the state agency (this is in conflict with state and federal law as injuries of unknown origin are indicators of abuse and are to be reported within 2 hours of identification). The DNS could not identify how she determined that the bruise on Resident #16's forehead was caused by the resident bumping the mechanical lift bar but stated she would not have signed off on the assessment if she had not been sure that occurred. Additionally, the DNS noted that she might have additional interview statements in her office. However, she stated that it is ultimately the responsibility of the unit manager to follow up on all Accident/Incident reports to ensure they are complete. Follow~up interview with the DNS on 4/24/26 at 9:46 AM identified that she was unable to locate any additional interviews or documentation regarding the discoloration to the resident's left eyebrow which would indicate that Resident #16 had hit his/her head on the mechanical lift bar during a transfer. Review of the Abuse, Neglect and Exploitation Policy directed that possible indicators of abuse include but are not limited to physical marks such as bruises or patterned appearances and physical injury of a resident of unknown source. Additionally, reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specified timeframes: immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Additionally, an immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur. Written procedures for investigation include identifying and interviewing all involved persons including the alleged victim, witnesses and others who might have knowledge of the allegation, focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and the cause and providing complete and thorough documentation of the investigation. The Administrator will (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow up and report the results of the investigation when final within 5 working days of the incident as required by state agencies.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and interview for 1 of 8 sampled residents (Resident #16) reviewed for accidents, the facility failed to update/ revise the resident's care plan for behaviors. The findings include: Resident #16's diagnoses included dementia, cerebral infraction, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #16 had a Brief Interview of Mental Status of 3 indicating severe cognitive impairment. The assessment also noted totally dependent on staff for transfers, changing positions in bed (rolling left to right and sitting to lying), and personal hygiene. The Resident Care Plan (RCP) dated 12/4/25 identified Resident #16 had potential impairment to skin integrity related to inactivity. Interventions included: using caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces and to follow facility protocols for treatment of injury. A nurse progress note dated 1/22/26 at 7:30 AM identified Resident #16 had a change in condition consisting of a reddish/purplish discoloration to the left eyebrow caused when he/she bumped his/her forehead lightly against the mechanical lift bar during transfer. Post event, the resident acquired a reddish/purplish discoloration above his/her left brow, skin was intact, neurological checks within baseline/normal limits and no complaints of pain or discomfort were noted. Interview with RN #1 on 4/22/26 at 2:40 PM identified she believed the discoloration may have occurred because Resident #16 was a total mechanical lift transfer, becomes anxious, and often grabs the bar, which could cause him/her to bump against the machine or by pulling up on the side rail during care, which could have also lead to a bump and discoloration of the skin. RN #1 identified that she was aware Resident #16 became anxious during transfers prior to the incident. However, RN #1 indicated she did not care plan for anxious behavior, even though she was responsible for updating care plans. Review of the Comprehensive Care Plan Policy revised 1/15 given onsite notes the facility will develop an individualized comprehensive care plan for each resident. Additionally, each resident's comprehensive care plan was designed to incorporate identified problem areas and incorporate risk factors associated with identified risk problems. The Care Planning/Interdisciplinary Team is responsible for periodic review and updating of care plans: when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility after a hospital stay and at least quarterly.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #117) reviewed for Activities of Daily Living (ADL), the facility failed to ensure Resident #117 was ambulated per physician's orders. The findings include: Resident #117 was admitted in March 2026 with diagnoses that included congestive heart failure, respiratory failure and spinal stenosis. Physician's orders dated 3/23/26 directed, in part, physical and occupational therapy as indicated. Physician's orders did not address Resident #117's ambulation or transfer status. The Resident Care Plan (RCP) dated 3/24/26 identified activities of daily living (ADL) deficit and self-care performance related to decreased strength and endurance. Interventions included: assist of 1 ADL seated, assist of 1 ambulation to/from bathroom with rolling walker (RW), assist of 1 for transfers with RW, assist of 1 for bed mobility, assist of 1 with toileting and therapy as indicated. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #117 was cognitively intact and had a Brief Interview for Mental Status score of 15 and required maximum assistance of 1 staff member for activities of daily living including ambulation. Physical therapy notes indicated that Resident #117 was discharged from physical therapy on 4/10/26 due to insurance. Resident #177 was able to ambulate with assistance of 1 staff member in the room and hallway using RW as tolerated. Physician's orders on 4/17/26 directed, in part, ambulation with assistance of 1 staff with RW. Interview with Resident #117 on 4/21/26 at 9:16AM identified she/he recently moved rooms from the short-term unit to a long-term care unit. Resident #117 indicated her/his room change occurred around the 10th of April. Resident # 117 stated that she/he had not been receiving therapy since his/her room change and believed it was due to insurance reasons. Resident #117 indicated she/he was informed by therapy that staff would walk him/her daily when she/he was moved to his/her new room. Resident #117 indicated that staff had not walked him/her since the room changed and they were using the wheelchair even to take him/her to the bathroom. Resident #117 was concerned she/he was not being walked and wanted reassurance that she/he would be walked as needed to gain strength to eventually go home. The Nurse Aide (NA) flowsheets reviewed from 4/17/26 through 4/23/26 lacked documentation Resident #117 had walked in his/her room or in the hallway from 4/17/26 through 4/19/26. NA documentation from 4/17/26 through 4/19/26 indicated not applicable (N/A) for all 3 shifts. In addition, there was documentation that Resident #117 had only walked 4 times in the hallway on 7-3 shift and 5 times in his/her room (4 times on the 7-3 shift and 1 on 3-11 shift) from 4/20/26 through 4/23/26. The NA flowsheets indicated N/A for the rest of the shifts during that timeframe. Interview with Director of Therapy (PT) 1 on 4/23/26 at 10:45AM indicated Resident #117's physical and occupational therapy had been discontinued on 4/10/26 due to insurance purposes and Resident #117 had just restarted physical therapy on 4/20/26 as they had received approval from Resident #117's insurance. PT #1 stated when Resident #117 was discharged from therapy, she/he was able to walk with staff. PT #1 indicated that Resident #117 was placed on the ambulation program on 4/17/26. PT #1 stated there was verbal communication to the nursing supervisor on unit 300 that Resident #117 could be added to the ambulation list and a physician's order could be obtained to walk daily with assistance with RW as tolerated. PT #1 was not aware that nursing staff had not consistently ambulating Resident #117 since his/her discharge from therapy. PT # 1 indicated Resident # 117's new evaluation on 4/20/26 did not indicate Resident #117 had a decline in his/her ADL status including ambulation from 4/10/26 through 4/20/26 when she/he was picked up again by therapy. Interview with NA #1 on 4/23/26 at 2:00PM indicated that she would check the ambulation list on the unit to review who needed to be ambulated on her shift. However, NA #1 could not locate the ambulation list for the unit. NA #1 indicated she could also check a resident care card to find out if a resident needed to be ambulated. NA #1 was unable to state if Resident #117 needed to be ambulated. Interview and review of the NA flowsheet documentation and care card with the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Director of Nursing Services (ADNS) on 4/23/26 at 2:10 PM indicated there is usually an updated ambulation list on the unit, but she could not locate the list. She indicated the unit manager had been off for over a week who usually is responsible for posting the sheet on the unit. However, she was able to locate the physician's order and the updated care card for Resident #117 indicating she/he was able to ambulate with staff assistance. The ADNS indicated that NAs should check the resident's care card as it usually indicates if a resident needs to be walked. The ADNS indicated it was a new process to place the ambulation status of a resident on the care card in effort to try to eliminate the use of the ambulation sheet. Though, the ADNS could not state or locate any education related to this new process for NAs. Furthermore, the ADNs indicated that the NAs should have been walking Resident #117 starting 4/17/26 and documenting appropriately on Resident #117's flowsheet. After inquiry, an updated ambulation list of residents was provided to the unit 300 on 4/23/26. A review of Rehabilitative Nursing Policy given onsite, directed, in part, nursing personnel are trained in rehabilitative care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident care plan. The facility's rehabilitative nursing program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. Rehabilitative nursing is performed daily for those residents who require such services as prescribed by the attending physician.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and review of facility policy for 1 of 1 resident (Resident #85) reviewed for blood glucose monitoring, the facility failed to maintain appropriate infection control practices during blood glucose monitoring. The findings include: Resident #85 was admitted to the facility in February 2014 with diagnoses that included type 2 diabetes, dementia, and depressive disorder. The annual Minimum Data Set (MDS) dated [DATE] identified Resident #85 had a Brief Interview for Mental Status (BIMS) score of three (3) indicative of severely impaired cognition and dependent with personal hygiene, dressing, and toileting. Additionally, the MDS identified Resident #85 received insulin 7 days a week. Physician's orders dated 3/12/26, directed to perform blood glucose monitoring twice a day, administer Toujeo Solostar (long-acting insulin used to lower blood sugar) 60 units subcutaneously (under the skin) once a day, and Tradjenta (medication used to control blood sugar) 5 milligrams (mg) once a day for diabetes. The Resident Care Plan (RCP) dated 4/2/26 identified Resident #85 had diabetes with interventions that included diabetes medications as ordered, diet as ordered, monitor compliance with diet, inspect feet daily, podiatry consultation, and labs as ordered. Observation on 4/23/26 at 7:20 AM of Licensed Practical Nurse (LPN) #2 performing Resident #85's blood glucose monitoring identified LPN #2 entered the room wearing gloves applied prior to entry, carrying a blood glucose meter, a multi-vial test strip bottle, lancet, alcohol wipes, gauze, and gloves. Resident #85 was in bed lying on his/her back, LPN #2 placed the blood glucose meter directly on Resident #85's blanket on the bed (without the benefit of placing a barrier on the blanket). LPN #2 removed a test strip from the multi-vial test strip bottle, inserted the test strip into the blood glucose meter, cleansed Resident #85's right index finger, used a lancet to puncture the finger, applied the blood sample to the test strip, and the meter displayed an error message. LPN #2 removed the strip from the meter, then without the benefit of removing her gloves or sanitizing her hands, she obtained another test strip from the multi- vial bottle and attempted a second sample from the same finger without a new puncture; the meter again displayed an error. LPN #2 exited the room with the meter and supplies, discarded the used items, placed the blood glucose meter on the medication cart without the benefit of disinfecting the meter, then removed her gloves and performed hand hygiene. LPN #2 donned a pair of gloves, re-entered Resident #85's room, placed the blood glucose meter on Resident #85's roommate's over-bed table without placing a barrier on the table. LPN #2 obtained a strip from the multi- vial test strip bottle, inserted into the blood glucose meter, obtained Resident #85's blood sample, and obtained a blood sugar reading. LPN #2 then exited the room, placed the blood glucose meter and supplies on the medication cart, removed her gloves, performed hand hygiene, and disinfected the meter. Interview with Nurse Aide (NA) # 3 on 4/23/26 at 7:45AM identified she assigned to Resident #85 and his/her roommate for the 7:00 AM to 3:00 PM shift. NA #3 indicated the over-bed table located in the middle of the room, positioned between the privacy curtain and near the foot of the bed, belonged to the roommate of Resident #85. Interview with RN #1 on 4/23/26 at 7:50AM identified LPN #2 should not have placed the blood glucose meter on Resident #85's blanket or the roommate's over-bed table. RN #1 stated LPN #2 should have placed the blood glucose meter on a clean surface by first disinfecting the area and placing a barrier beneath the device. RN #1 further stated LPN #2 should not have brought the multi-vial test strips bottle into Resident #85's room. RN #1 identified she was not familiar with all the specific details of the blood glucose monitoring policy, but any potential contamination of the meter requires disinfection in accordance with manufacturer guidelines, and the meter should always be placed on a clean surface. Interview with LPN #2 on 4/23/26 at 8:00AM identified she should not have placed the blood glucose meter Resident #85's blanket on the bed nor should she have placed the meter on top of the roommate's over-bed table. LPN #2 indicated only one test strip should have been brought into the room, rather than the entire multi-vial bottle. LPN #2 stated she should have cleaned the blood (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glucose meter and set aside after the initial blood glucose monitoring attempt, and that a spare meter from the medication cart should have been used when reattempting blood glucose monitoring for Resident #85. LPN #2 indicated she was nervous at the time, which caused her the errors made when performing Resident #85's glucose monitoring. Interview with LPN #4 (Infection Control Nurse) on 4/23/26 at 11:00AM identified blood glucose meters should be placed on a clean surface, such as on a table with a barrier and it is not appropriate to use another resident's over-bed table. LPN #4 identified blood glucose meters should be cleaned after exiting a resident room, before placing it on top or in the medication cart, even if the blood glucose meter will be used again in the same room. Review of facility Blood Glucose Policy dated 10/25/26 directed in part, the facility will ensure blood glucose meters will be cleaned and disinfected after each use according to manufacturer's instructions. Gloves should be removed and hand hygiene prior to exiting room. Gloves should be reapplied if visibly soiled or contaminated.		